Division of Health Care Finance & Administration | Health Care Innovation Initiative

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Primary Care Transformation: The Care Coordination Tool

What is a Care Coordination Tool?

Care coordination or care management tools help health care providers coordinate and track their patient's health care services. Providers need access to reliable, easy to use data in order to deliver more effective, quality care to their patients. To this end, TennCare is building a shared, web-based, care coordination tool. This type of technology is relatively new nationally, putting Tennessee at the cutting edge of making a tool like this available to primary care and behavioral health providers in the state.

Tennessee's Care Coordination Tool is being customized for the State by Altruista Health and has been designed based on recommendations from Tennessee providers. It is specifically intended to meet the needs of providers participating in the State's Tennessee Health Link and Patient Centered Medical Home (PCMH) programs. Provider feedback on the tool was gathered during a 2016 pilot to help ensure it delivers useful, actionable information to providers that can be incorporated into a variety of workflows.

Key Features of the Tool

The Care Coordination Tool lets providers track their patients' gaps in care, risk scores, and hospital stays. The tool helps providers sort and prioritize their attributed patients by diagnoses and risk profiles and allows providers to view and track their patients' gaps in care in order to better outreach to patients and schedule follow up visits.

Key features of the tool include allowing providers to:

- View their panel of attributed patients for Tennessee's PCMH and/or Health Link programs,
- Receive notifications of admission, discharge or transfer from a hospital or emergency room for their patients,

- View their patients' risk scores, which allows for the prioritization of future actions,
- View their patients' gaps in care and track the completion of identified care opportunities (such as diabetic screenings and immunizations).

In the future, primary care and behavioral health providers will also be able to see when their patients have filled prescriptions in more real time. Currently, pharmacy claims information is viewable in the tool.

Care Coordination Tool Users

This tool can be used by care coordinators, practice administrators, care managers, doctors, nurses, social workers, or anyone else in a provider's office who helps coordinate and track health care services for patients.

Users can sign up to use the tool as:

- **Administrators:** They have the ability to assign patients to specific Care Coordination Tool users in their provider organization. They are also in charge of removing users that leave a provider's practice.
- **Care Coordinators:** They can view and update any information in the tool.
- **Providers:** They can view and update any information in the tool.
- **Care Team Managers:** They can oversee the performance of a team of care coordinators.

Data sources for the Care Coordination Tool

The main source of data in the tool is paid claims. Claims data are used to determine patient diagnoses, pharmacy information, and risk scores. Gaps in care identified by the tool are based on claims data as well as a practice's own self-reported gap in care closures. Due to claims lag and processing time, it can take up to 9 weeks for the tool to reflect a claim from the time it is submitted for payment.

Patient risk scores in the Care Coordination Tool are calculated using the Chronic Illness and Disability Payment System (CDPS) risk adjustor. This is a validated tool created by the University of California, San Diego. It is used by multiple states' Medicaid programs as well as private insurers. CDPS works by adding risk across a

variety of disease categories to calculate a risk score for each individual patient. Risk categories are determined based on a stratification of the risk scores into the critical, high, medium-high, medium and low risk categories.

The tool also includes member attribution information from the TennCare Health Plans used to identify which patients are attributed to which providers. Also, the Tennessee Hospital Association is working with the State to ensure more hospital admission, discharge, and transfer information is fed into the tool by Tennessee hospitals.

Care Coordination Tool Tabs

The Care Coordination Tool has several interactive tabs that users can click for more information about their patients.

In the **My Members** tab a user can view a practice's attributed patients and key patient information such as risk category and health insurance carrier. In this tab a user can search and sort patients by disease and by risk category. These actions can be combined with the identification of care opportunities in order for providers to prioritize outreach to patients.

The **Quality Measures** tab allows users to view their patients and see if there are gaps in care that need to be addressed. The quality measures in the tool are quality measures specifically used in the State's PCMH and Health Link programs. Users can view the quality measures that need to be addressed for a given patient, and track the progress and completion of each gap in care. Users can also export quality measure information into an Excel spreadsheet for use outside of the tool.

In the **Admission/Discharge** tab, users can view admission, discharge, and transfer information for their attributed members, including whether one of their patients was admitted to the hospital or had an emergency department visit. Users can also track activities related to the admission, such as scheduling follow up visits.

By utilizing the **Population Health Dashboard** tab users can see where they are with their patient population as a whole. They can see an overview of what gaps in care have been closed for patients, including those which have been manually closed versus those that are confirmed closed by a claim.

Users can also view their patients' diagnoses, prescriptions, and patient care plans as well as schedule future activities on a calendar.

Training Materials for the Tool

The State provides a demonstration video and training materials for the Care Coordination Tool on their website: http://www.tn.gov/hcfa/article/care-coordination-tool. Training materials are organized by the tabs in the tool.

On a quarterly basis the State and Altruista Health lead web-based training sessions for new Care Coordination Tool users. It is recommended that new users review training materials prior to using the tool. To join an upcoming training, email hcfa.spigcct@tn.gov. New users are also included in mailings about upcoming Care Coordination Tool training sessions.

Who to Contact

If you **want access to the Care Coordination Tool** and haven't received a user name and password yet, contact your practice's point of contact for the Care Coordination Tool. If you do not know who that is, email hcfa.spigcct@tn.gov.

If you have already received your user name and password and are **having trouble using the Care Coordination Tool or have questions**, contact the Altruista Help Desk at 855-596-2491 or support@altruistahealth.com.

Frequently Asked Questions (FAQs)

When will more providers gain access to this tool?

Providers participating in the State's PCMH and Health Link programs are currently given priority for accessing the tool. In the future, the tool will be made available to any Tennessee primary care providers who wish to participate. The Care Coordination Tool is geared towards primary care providers. However, in the future we are exploring the utility of this tool for specialty providers as well as hospitals.

Can two provider organizations see the same patient's information?

Yes, only if a patient is attributed to both a PCMH and a Health Link provider. There is a single patient record in the tool so that patients shared between two providers can coordinate care. An organization can only see members attributed to their organization at a tax ID level.

Why is substance use information not available in the tool?

No information on substance use or treatment is available in the tool due to federal regulations. Therefore, information related to the initiation/engagement of alcohol and drug dependence treatment (IET) quality measure for Health Link is not available in the tool.

Can providers export information out of the tool?

Users can export information to Excel from the tool. In future releases information will also be exportable in the form of a CCD-A using DIRECT messaging protocol. Also, internal messages can be sent to other practice staff using the tool, with expanded functioning of messaging to outside users of the tool being rolled out in the future.

Where can I get more information about the risk score?

More information about CDPS can be found at http://cdps.ucsd.edu/.

Why is some information missing from the tool?

Because the tool uses claims data, there is a lag in what is available in the tool. A health care service may take a few months to show up in the tool after it is rendered due to normal claims processing times. In addition, there are several services which are not fully captured in claims. For example, vaccination information is not complete in the tool since TennCare does not process claims for vaccines covered by the Tennessee Vaccines for Children program. TennCare is currently working with the Tennessee Department of Health to get the Vaccines for Children information into the Care Coordination Tool.

Does this tool replace the HEDIS quality measure reporting a practice already does?

No, this tool does not change any HEDIS quality measure reporting or attestations that you are currently doing for the TennCare Health Plans. HEDIS

scoring will be based on the data you send directly to the Health Plans either through claims submissions or supplemental data. Attestations in the Care Coordination Tool will not contribute to your final HEDIS outcome.